

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17049

State File No.

FILED JUN 7 1949

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2274

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. TBC Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-28-43-
(Specify whether years, months or days) 5-12-43

3. (a) PRINT FULL NAME MARTINEZ, Joseph

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE obtained

4. Sex M 5. Color or race Mexican 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct. 2 1880
(Month) (Day) (Year)

8. AGE: Years 62 Months 7 Days 910 If less than one day hr. min.

9. Birthplace Mexico
(City, town, or county) (State or foreign country)

10. Usual occupation Watchman in store

11. Industry or business Peter Martinez

12. Name Mexico 13. Birthplace Mexico
(City, town, or county) (State or foreign country)

14. Maiden name MARY BARBOZA 15. Birthplace Mexico
(City, town, or county) (State or foreign country)

16. (a) Informant Records K.C. TBC Hosp. (b) Address 76-C-2nd

17. (a) Removal (b) Date thereof 5-18-43
(City or town) (County) (State)

(c) Place: burial or cremation Kershaw College of Osteo. Mo.

18. (a) Signature of funeral director Western Funeral Home (b) Address 2332 Montmar Pl. K.C. Mo.

19. (a) 5-17-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town KANSAS CITY, MO. 3
(If outside city or town limits, write "RURAL")
(d) Street No. 6928 Vasco 8
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Mexico

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 12
year 1943 hour 1 minute 45 A. M.

21. I hereby certify that I attended the deceased from 4-28-43
19 to 5-12-43
that I last saw him alive on 5-12-43
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis 24 yrs

Due to 1943

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) By Means of injury

23. Signature William T. Sheppard M.D. (M.D. or D.O.)
Address Kansas City, Mo. Date signed 5-12-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Oscar Samuelson

Licensed Embalmer No.

3002

P. O. Address

2332 Monroe St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.